**MEDICAL IN CONFIDENCE**



**HELLENIC CIVIL AVIATION AUTHORITY**

**FORM FOR CHANGE OF ISSUING COUNTRY OF THE MEDICAL CERTIFICATE**

|  |  |  |  |
| --- | --- | --- | --- |
| **ITEM** | **DESCRIPTION** | |  |
| 1 | State of Transfer FROM:  Address:  Telephone:  Email | | Hellenic Civil Aviation Authority H.C.A.A.  A.M.S  BUILDING 45  Athens International Airport ELEFTHERIOS VENIZELOS  Po BOX 19019 Spata GREECE  E-mail: [ams@hcaa.gov.gr](mailto:ams@hcaa.gov.gr) |
| 2 | State of Transfer to:  Address:  Telephone  Fax  Email | |  |
| 3 | Licence held: | Type: |  |
| Reference |
| 4 | Full name of holder | |  |
| 5 | Address of holder | |  |
| 6 | Date of Birth (dd/mm/yyyy) | |  |
| 7 | Nationality of holder | |  |
| 8 | Limitations (if any) | | - |

|  |  |  |
| --- | --- | --- |
| **ITEM** | **DESCRIPTION** |  |
| 9 |  | |
| CONSENT **CONSENT RECEIVED VIA EMAIL** | | |
| I,(Name of applicant) ……………………………………consent to my AeroMedical records being transferred to the Authority Medical Section of the Licensing Authority of the ……………… CAA .  Signature: …………………………………………….. Date (dd/mm/yyyy): | | |
| VERIFICATION | | |
| I, (name), Dr ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,of the Hellenic Civil Aviation Authority, certify that the details given above  and on any additional pages included are true and correct.  Date (dd/mm/yyyy): 22/03/2023 | | |
| Signature and Medical Assesor stamp | |  |